TEXAS DEPARTMENT OF HEALTH

Policy Brief

**Current Public Health Policy Research
And Its Implications For Texas**

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HOW EARLY IS TOO EARLY?

Issue

The debate over optimal hospital stays for mothers and newborns is escalating: lengths of stays are decreasing, but for the benefit of whom?

Background

In 1970, the average hospital stay after an uncomplicated vaginal birth was four days. By 1992, it had been reduced to about two days. Today, the national average stay for an uncomplicated birth is around 24 hours, and dropping (NPR 1995).

Comprehensive Texas data regarding obstetrical lengths of stay are lacking. Based on the available information, however, lengths of stay appear to be a little higher than the national average. At least half of all the state's deliveries are paid through Medicaid, and the average hospital stay following an uncomplicated vaginal birth (nearly 60 percent of all Medicaid deliveries) is 1.68 days (TDHS 1994). Currently there are 40 Health Maintenance Organizations (HMOs) licensed to operate in Texas; the number changes frequently. Each HMO determines its own policy, when applicable, for obstetrical stays; there is no central determination of policy or collection of this information in the state.

Some professionals, in support of decreasing hospital stays, cite the need to treat pregnancy as a healthy rather than an illness state and/or note the risk to healthy newborns in germ-infested hospitals. Most professional, however, believe that shorter pregnancy stays for uncomplicated deliveries are an effort by insurance companies and HMOs to control health-care costs.

No one will dispute the fact that limiting pregnancy stays does save money. For managed-care companies, births constitute roughly 20 percent of all hospital admissions; each night of hospitalization costs between $1000 and $1800 for mother and newborn (UMDNJ 1995). With nearly 4 million babies being born each year, limiting pregnancy stays would result in annual savings of billions of dollars (Boodman 1995). Because of this potential for cost savings and the requirements and limitations of managed care, many insurance companies are refusing to pay for more than 24 hours of maternity care after an uncomplicated vaginal birth (Begley 1995).

HMOs and insurers that have been experimenting with early-discharge programs have reported high patient-satisfaction levels and low readmittance rates (Anderson 1991). Review of these programs, however, indicates that there usually strict guidelines associated with early discharge eligibility such as proper prenatal care, permission of the obstetrician, low medical risks, and an adequate family-support system. Most plans either offer home visits by nurse practitioner following discharge

or have decreased the amount of time before the recommended follow-up visit from two weeks to 48 hours. Researchers from these organizations report that no significant morbidity or mortality could be attributed to early discharge with home follow-up evaluations (Anderson 1991).

Critics of limited post-delivery stays agree that although most mothers are not going to have a catastrophic event upon leaving the hospital, this practice limits the chances of helping those who may. Problems that can occur for the mother include the possibility of hemorrhaging (if she re-injures tissue torn during labor) or an infected episiotomy (a surgical incision to facilitate delivery). New mothers can also be insecure about their new role, inexperienced or fatigued. For the newborn, results can be much more catastrophic if problems such as jaundice or difficulties suckling go undetected. Blood tests and/or screening, which are important for diagnosing serious long-term conditions, are not reliable until at least 48 hours after birth; many children are not tested following discharge (Capitol Publications 1995).

Physicians have reported that even though eligibility for an early discharge program is presumably at the discretion of the doctor, some HMOs have threatened contractual termination if early discharge is not recommended. There have also been reports of insurance companies' refusal to pay for the follow-up visits that are recommended as part of the early-discharge program, and even reports of blanket 24-hour limits on pregnancy stays without regard to early-discharge criteria (Boodman 1995).

Proponents

Some state hospital associations do not support longer hospital maternity stays. The director of maternal and children's health at the Hospital Association of Pennsylvania, for example, believes the chances of infection become greater the longer newborns remain in the hospital, and claims that at least two studies have shown that mothers who stay in the hospital longer have higher levels of postpartum depression (Hudson 1995). Others, both in the insurance industry as well as academia, are uncomfortable with recent legislative drives to mandate certain kinds of medical practices; states regulate insurers but don't usually - until recently - tell them how to deliver care.

Opponents

In May 1995, the American College of Obstetricians and Gynecologists - which recommends that new mothers spend at least 48 hours in the hospital after an uncomplicated vaginal birth and 96 hours after a caesarean delivery - called for a moratorium on 24-hour stays while challenging insurers to prove that they are safe. (The American Academy of Pediatrics also recommends the 48-hour and 96-hour minimums, respectively.) In June, the American Medical Association passed a resolution urging that potential discharges be "determined by the clinical judgement of attending physicians and not by economic considerations" (Boodman 1995). In November 1995, the Texas Medical Association adopted a postpartum discharge policy requiring insurers to cover at least 96 hours of inpatient care after an uncomplicated Caesarean delivery (TMA 1995). In addition, the Texas Hospital Association holds that "medical necessity, and not financial incentives/restrictions, should dictate the lengths of stay for mothers and newborns... [these] should be based upon sound clinical guidelines applied by a physician or nurse midwife" (THA, 1996).

State and federal government

As noted earlier, this debate has attracted the interest of state and federal legislators. There is

currently a bill pending in Congress that is sponsored by Senator Bradley (D-NJ) which mandates minimum hospital stays for mothers and newborns (S.969). Similar legislation has already been passed in New Jersey, Maryland and North Carolina (UMDNJ 1995).

The bill currently before the U.S. Senate Committee on Labor and Human Resources, *The Newborns' and Mothers' Health Protection Act of 1995,* mandated maternity-benefits health plans to ensure coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a Caesarean delivery. An exception to this rule would be made if the health plan provides home care for the patient in lieu of inpatient care (unless inpatient care is specifically requested by the attending physician). Many believe this bill will stay in committee.

The bill signed June 28 by New Jersey Governor Christina Todd Whitman has the same basic tenets as the federal legislation: New Jersey insurers can only institute a 24-hour stay if three home visits are covered, and early discharge is at the discretion of the mother and the attending physician (George Washington University 1995).

The Maryland bill requires insurers and providers to follow standards set forth by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The standards recommend that new mothers spend 48 hours in the hospital after childbirth; newborns may be released before two days have elapsed only if they meet the criteria for medical stability, or if the plan covers initial postpartum home visits. The bill also mandated insurers to encourage expectant mothers to select and make contact with a primary-care provider before their baby's deliver (George Washington University 1995).

North Carolina has also enacted legislation to safeguard a 48-hour length of stay and, according to the University of Medicine and Dentistry of New Jersey (1995), other states such as New York, Pennsylvania, California, Illinois, Massachusetts, Delaware and Rhode Island are considering comparable bills.

Summary

The proper length of a hospital stay after birth is a complicated issue as it encompasses medical, emotional and financial concerns.

There has been no legislative action on this issue in Texas to date. The new Texas Health Care Information Council, however, was created by the 74th Legislature to collect and provide comprehensive health care information - including obstetrical lengths of stay - that can be used for both policy analysis and decision making. This information will no doubt be useful in determining appropriate lengths of stay - that can be used for both policy analysis and decision making. This information will no doubt be useful in determining appropriate lengths of stay for mothers and newborns within the confines of containing the burgeoning costs of health care while striving for high quality in our health-care delivery system.

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UPDATE:

1. The Newborns' and Mothers' Health Protection Act of 1995 (S.969) was passed out of the U.S. Senate Committee on Labor and Human Resources on April 17, 1996.
2. For a detailed fact sheet related to this Policy Brief topic, "How Early is Too Early?", call Pisa Lewis at 512/458-7261 or send an E-mail to plewis@dpa.tdh.state.tx.us

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